PETITIONS AND PATHWAYS TO THE ASYLUM IN BRITISH MANDATE PALESTINE, 1930-1948*

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Abstract. This article draws on a collection of petitions by Palestinian Arabs and Jews to explore how families negotiated the admission of mentally ill relatives into government mental institutions under the British mandate between 1930 and 1948. In contrast to the conclusions of the existing literature, which focuses largely on the development of parallel Jewish institutions as establishing the foundations of the Israeli health system, these petitions reveal that the trajectories of both Arab and Jewish mentally ill were complex, traversing domestic, private, and government contexts in highly contingent ways. The second part of this article examines the petitions themselves as dense moments of engagement by Palestinian Arabs and Jews with the British mandate, in which the anxieties and priorities of the mandate were strategically re-deployed in order to secure admission into chronically underfunded and overcrowded institutions. Petitioners also sought to mobilise other actors, often within the state itself, as intercessors, a strategy which attempted to thread together state and society in a meaningful and advantageous way at a time when both seemed to be unravelling. Taken together, these pathways and petitions foreground the space of interaction between the British mandate and its subjects, thereby offering new perspectives on both.

From the early 1930s, the British mandatory government in Palestine was flooded with petitions on the subject of the mentally ill. As has been remarked for other colonial contexts, the idea that the British engaged with the question of mental illness likely comes as a surprise.[1] If there is a

general expectation that colonial states were unlikely to direct resources in this direction, in the case of Palestine that expectation is compounded by an image of the British mandate as merely the backdrop against which the central Arab-Jewish drama played out. Zeina Ghandour has memorably mocked this imagining of 'a hand-wringing British arbitrator despairing over his hot-headed Semitic clients'.[2] While Ghandour and others have drawn attention to the British state's active pursuit of imperial ambitions in Palestine,[3] this article offers an alternative perspective on the mandate by turning to the rich collection of petitions found within the colonial archive. These petitions reveal the complex ways in which the mandate's processes and institutions became incorporated into the strategies of families and communities as they sought care for their mentally ill members. They can be read as re-deploying the mandate's anxieties surrounding mental illness in order to capture its attention, make claims upon its resources, and, ultimately, secure admission to its chronically underfunded and overcrowded mental institutions. This article thus returns us to a field marked for investigation two decades ago by Ann Laura Stoler and Frederick Cooper, but overlooked in the historiography on Palestine – that 'between the public institutions of the colonial state and the intimate reaches of people's lives'.[4] Even within the wider literature on colonial concerns about the intimate, however, the focus has been on poor whites, or somatic contacts within the settler home; to put it another way, on Europeans slipping out of their proper place.[5] The petitions examined here do not share this focus, and reveal a different register of anxieties. These petitions, which urged the colonial state to take charge of the minds and bodies of petitioners' relatives, rather reveal a state overwhelmed by the scale of its responsibilities in the most intimate realm of all.

While there is a developing literature on petitioning in Palestine, the focus of this work has been petitions whose authors were concerned with sovereignty, citizenship, and self-determination.[6] This is not to say the petitions examined in this article are apolitical. For these petitions, though asking for admission to government mental institutions, relied on a particular vision of the state, and had political effects. This is a point made by Ilana Feldman, in her

analysis of a petition from 1941 by residents of Gaza on water services. Even this everyday issue throws light on the wider political context, particularly the development of government. The expansion of the provision of services like water was not, she argues, just about increasing control over the lives of subjects, but served to multiply government responsibilities in ways which opened up new spaces and styles of interaction and challenge by subjects.[7] In much the same way, petitions about admission to government mental institutions necessarily relied upon certain expectations about what the state did, expectations which the state often helped shape but did not always accept as constituting binding obligations. Petitions thus paint a particular picture of the operation of the mandate itself, not just Palestinian apprehensions of it; they are revealing in relation to both petitioner and petitioned. The petitions examined here have much to say about the ways Palestinians understood and misunderstood the state, its workings, and its modes of thinking. But they also offer an insight into the nature of the mandate's engagement with mental illness. In his article on another British colonial asylum, that in Rangoon, Jonathan Saha argues that while an institutional history of British attitudes to insanity suggests a general indifference, punctuated by flurries of reform in the wake of scandal, turning our eyes elsewhere uncovers rather different narratives. In his case, focussing on courts rather than hospitals reveals how questions of insanity were the subject of sustained and serious consideration by British authorities.[8] Petitions, and the correspondence and actions they generated, offer another perspective. Rather than lurching from crisis to crisis, or taking an active or thoughtful interest in the complex legal questions surrounding insanity, the petitions reveal the mandate as under almost continuous pressure from a dizzying array of directions to care for – or at least confine – the mentally ill.

But the mandate was not wholly passive in relation to the question of mental illness. One of the ways it shaped the expectations of petitioners, at a very basic level, was by its provision of medical services for the mentally ill. At the start of the British occupation in 1917, the only mental institution in Palestine was a Jewish charitable institution in Jerusalem, the Ezrath

Nashim home, established in 1895. In 1922, the first government mental hospital was opened at Bethlehem, but it was in the 1930s and 1940s that provision for the mentally ill expanded most significantly, as a second mental hospital, also at Bethlehem, was founded in 1932, and a third, this time at Jaffa, in 1944. If, as Feldman has argued, the expansion of the provision of services also worked to expand expectations of government, then this timeline suggests one possible reason why petitions on the subject of the mentally ill only appear in the archive from the 1930s on. This issue is complicated by the destruction of many of the mandate's files in and after 1948.[9] It is possible petitions were written earlier, but have simply not survived amongst the mandate files in the Israel State Archives. While a few petitions not extant in that archive can be found in municipal archives, the number of petitions on this subject in the Israel State Archives dwarfs any comparable collection elsewhere; this article therefore concentrates on that archive's collection of petitions, which were written in English, Arabic, and Hebrew, and are interlaced in the archive with the government's translations, acknowledgements, and internal correspondence.[10]

In spite of the expansion of the provision of services, government institutions never quite kept pace with demand. Thus, the Ezrath Nashim home was joined by a number of other private homes, especially after 1933, a proliferation made possible by the migration of German Jewish psychiatrists to Palestine. The existing work on mental illness and psychiatry has tended to focus on these figures, and the institutions they founded, as laying the foundations for the Israeli mental health service.[11] This article resists such a teleological and bifurcated approach by considering Arab and Jewish petitioners in the same frame.[12] In the first part, I draw on these petitions to argue that, just as the story of petitions under the mandate is not simply a story of political, constitutional, or legal petitioning, so too is the story of mental illness not simply one of the exploits of European Jewish psychiatrists. While histories of the development of professions, disciplines, and institutions are important, these petitions offer the possibility of recovering the social history of how families reckoned with illness in their midst. They reveal families – Arab

and Jewish – to have been active in seeking care for their mentally ill relatives, in plotting out complex therapeutic trajectories, and in drawing the state into these plans. The second part of this article focuses in on the strategies deployed by petitioners as they approached the state for succour. While there is much to say here about petitioner and petitioned alike, these strategies also reveal the 'stretch between the public institutions of the colonial state and the intimate reaches of people's lives' to have been a space of potential for the enterprising – and a treacherous one for petitioners who took the state at its word.

I

The routes taken by individuals as they moved in and out of mental institutions have long been of interest to historians. Two decades ago, David Wright called for a new approach to the history of the confinement of the insane in nineteenth-century Europe, emphasising the desires and strategies of families, rather than the ambitions of the developing psychiatric profession alone.[13] Though this was taken up more speedily by those working on the history of European psychiatry, there are now a number of works which acknowledge the complexity of the pathways taken by the mentally ill, and the importance of families in shaping those pathways, in the context of colonial psychiatric systems.[14] This shift in focus has gone hand-in-hand with a re-evaluation of the limits of thinking about the psy-sciences solely as a tool of governance.[15] As the petitions of the families of the mentally ill suggest, the case of Palestine is not exceptional in this respect: the paths taken by the mentally ill, Arab and Jewish, were complex, and shaped by multiple actors.

While this conclusion, in line with the wider historiography on colonial psychiatry, is hardly striking in itself, it does have important implications in the context of mandate Palestine. As in many other areas, the medical history of the mandate has been told largely in terms of

increasing distinction between the Arab and Jewish populations of Palestine.[16] Marcella Simoni has argued that, as part of the wider development of parallel Zionist state institutions, a separate welfare system emerged for Jews in Palestine to the government system, which was aimed primarily at the Arab population. This included the provision of care for the mentally ill.[17] While it is true that Jewish private institutions for the care of the mentally ill proliferated in a way not matched by similar institutions for the Arab population, the trajectories of Palestinian Arabs, as they moved in and out of different sites of care and treatment, were no less complex than those of Jews. Petitions enable us to trace these trajectories, and so complicate more straightforward narratives about the development of parallel institutional and experiential worlds for Arabs and Jews across this period; narratives which often work backwards from 1948, not the viewpoints of those actually living under the mandate.

The complexity of the experiences of the Arab mentally ill has been largely obscured by a static image of a cultural preference for managing the mentally ill at home. In the absence of any Arab private institutions, Simoni argues the Arab mentally ill were 'kept at home and cared for by their relatives'.[18] In this, she echoes the opinions of some at the time. Dr Abraham Rosenthal, a Russian psychiatrist who arrived in Palestine in 1924, described how 'the rural population, owing to its primitive Oriental psychology, usually keeps their mental sick at home, especially in the case of women'.[19] Although caring for mentally ill relatives at home has been presented in terms of cultural preference, the roots of this can be better located in structural and legislative factors, stretching back to the Ottoman law on lunatics of 1876. This law remained in force throughout the mandate, and assumed the care of the mentally ill would take place primarily in the home, an assumption which made sense, given the lack of mental institutions in the Levant in the late nineteenth century. Until a lunatic was 'in such a condition as to necessitate his being bound',[20] the law assumed they could be adequately cared for at home; after that point, the government was to be informed. That this law shaped how families thought about their options into the mandate period can be inferred from a number of petitions requesting the admission of

relatives to government mental hospitals, which described these individuals as chained up at home. While – as we will see – presenting an individual as too dangerous to retain at home was also important in meeting the admission criteria set down by the mandate's department of health, the fact that such dangerousness was conveyed by reference to physical restraint points to the continued importance of the Ottoman law in shaping the treatment and representation of the mentally ill. While there are no 'typical' cases, that of S.M.S. Ayyad of Jaffa helps illustrate this point. The senior medical officer examined him in April 1935, and found him to be a lunatic 'of a type which cannot be controlled or attended to elsewhere than in hospital'.[21] While the medical officer represented the case in these colourless terms, the boy's mother wrote separately to the director of health. 'His conduct in the house is unbearable', she declared, 'and he must be fettered with chains, because he strikes and breaks whatever comes within his reach'.[22] A chronic lack of provision for the mentally ill, combined with the late Ottoman legislative legacy, helped shape the tactics used by Ayyad's mother to manage his condition.

Caring for mentally ill relatives at home was not the only option open to Palestinian Arab families, nor was it exclusively an option for Arab rather than Jewish families. Complicating the neat distinction drawn between the routes taken by the Arab and Jewish mentally ill, E. Frankel cared for her mentally ill son at home for eight years before she wrote to the high commissioner in April 1937 requesting his admission to a government institution.[23] In general, it appears Jewish families did seek to have their relatives admitted to private or government institutions more frequently – and earlier – than Arab families, but there were circumstances in which they too cared for mentally ill relatives at home for long periods of time. It is important, moreover, not to assume that remaining at home was uncomplicated or passive. In a number of cases, the mentally ill were visited and treated by doctors while at home. K.H. al-Dirr of Beit Hanina wrote to the high commissioner in January 1937 about his wife, whom he declared had been 'very dangerously and seriously insane' for over a year.[24] When she was examined, however, the medical officer reported that 'she was under treatment by several doctors, among whom was Dr

Hermann', of the nearby Ezrath Nashim home.[25] She was not unique in this respect.[26] Retaining a mentally ill relative at home was not always quite so backwards and detached from professional medical care as Rosenthal, for instance, made it appear.

But these references to private doctors also suggest the financial pressure under which the families of the mentally ill were operating by the 1930s and 1940s. I.A. Wahid of Jerusalem, writing to the director of medical services in May 1938 on behalf of his sister, noted that while she had been treated by several doctors over the last five months, he could no longer afford treatment for her, and requested she be admitted to a government institution.[27] Alongside these protests that families could no longer afford to pay private doctors to tend to their mentally ill relatives, there are pleas like that of A.A. Kamal, also of Jerusalem, who begged the health department to take responsibility for his wife because, as he put it: 'I am a poor man and unable to take care of her'.[28] It is possible to read such protestations of poverty as made in the hope of reducing – or escaping entirely – the fees charged by the government mental hospitals; certainly some went to extraordinary lengths to avoid these fees.[29] But the frequency of such references suggests one reason for the increase in petitions in the 1930s and 1940s may have been the impact of successive economic crises, starting with the global depression. Such an explanation would be in line with the conclusions of historians working on mental illness elsewhere: Claire Edington, for instance, has noted the colonial state's growing concern over the inability or unwillingness of families to take care of mentally ill relatives in the wake of the depression in French Indochina.[30] But on closer analysis, Palestine's experience diverges from this explanatory framework. Palestine was relatively insulated from the impact of the global depression;[31] in line with this, the number of petitions rose sharply in the second half of the 1930s, not the first. This suggests the importance of more local chronologies – above all the impact of strikes, rebellion, and counter-insurgency from 1936 onwards – in understanding the forces which drove families to seek institutional treatment for mentally ill relatives.

The representation of Palestinian Arabs as retaining mentally ill relatives at home requires qualification, then. But it is also important to probe the other side of this picture: the role of private institutions. As noted, private Jewish institutions proliferated in a way unmatched by private Arab institutions. It is important to ask why this was the case. At one level, this should be connected to the relative dearth of Arab psychiatrists who could, like their Jewish counterparts, have established private hospitals. This can be traced back to two interconnected phenomena, identified by the Palestine Arab Medical Congress in 1945. In the first place, there was the failure of the budget of the health department to 'meet the real needs of the country'. Second, the high number of licensed and practising Jewish physicians – including psychiatrists – was blamed for 'upsetting the normal proportion of Arab physicians to the Arab population by drawing a great number of their clients'.[32] In other words, the mandate never invested in building up a professional body of Arab doctors, specialists in particular, and those Arab doctors who did practice found themselves competing with ever-larger numbers of European Jewish doctors.

If the context was less than fertile for the organisation of private Arab medical institutions, it is possible to frame this differently, in terms of Arab engagement with – and active support for – government institutions rather than private ones. In a letter from November 1937, the director of medical services lamented that it would be impossible for the government to find the £P70,000 necessary for the construction of a new, desperately-needed mental hospital. But he reported talk 'from Arab sources that public subscriptions could be obtained towards the building fund for the new government mental hospital'.[33] This is the only document on the subject, so it seems the proposal was abandoned. The timing was certainly unpropitious, with the Arab revolt and discussions of partition underway; indeed, the timing makes it striking that such a proposal was floated at all, suggesting the willingness of some Arabs at least to throw their weight behind the government at a time when a question mark hung over the continued existence of any unitary state. While it would be incautious to arrive at any firm conclusion on the basis of this single reference, it parallels other instances in which Palestinians proposed

supporting the expansion of specific government medical services financially.[34] Together, these episodes suggest that the impulse to organize and fundraise amongst the Arab population need not, as with the Jewish population, have been directed towards establishing and maintaining separate private institutions for the care of the mentally ill, but towards improving government services; working with the government, rather than in parallel to it. While the literature has emphasized the way in which the Vaad Leumi and Jewish psychiatrists sought to apply pressure to the mandate government to raise the standards of its health services,[35] these instances highlight that initiative came also from the Arab population, even in the absence of an organized body of psychiatrists.

This is not to say that Palestinian Arabs were wholly dependent on government when they chose – or were forced – to pursue the institutional care of relatives. There were alternatives, above all sending relatives to institutions outside Palestine. The Asfuriyeh mental hospital in Lebanon was the most important of these, though there is evidence of Palestinians being sent to Egypt too.[36] The reports from Asfuriyeh record the number of Palestinians admitted to the hospital annually. While this number was rarely over ten, there were spikes: in 1937 and 1938 over forty patients from Palestine were admitted to the hospital.[37] This might be read as reflecting the impact of the Arab revolt on the workings of government mental institutions, but also on the rate of mental illness itself; it was, after all, those most able to afford private treatment at Asfuriyeh who found their position within the existing socio-economic order threatened by the revolt, in a way which may have been mentally as well as socially destabilising.[38] The importance of Asfuriyeh is clear from a large file in the colonial archive on the indebtedness of Palestinians to this institution from 1939.[39] In yet another instance in which the mandate appears not as active but rather reactive to Palestinian initiatives, officials found themselves chasing the families of patients at Asfuriyeh for payment of their debts.

There were alternatives within Palestine, too. Strikingly, Arab families were applying to Jewish private institutions for the treatment of relatives even into the late 1940s. The Supreme

Muslim Council wrote to the director of medical services in November 1946 about the sister of a sharia judge at Beersheba, who 'had a mental disease and was admitted to the hospital of nervous diseases in Haifa', that of Dr Kurt Blumenthal. The council requested she be transferred to the government mental hospital at Bethlehem, but only because the fees were too high at Blumenthal's.[40] She was not unique: Y.A. al-Masri, from Jerusalem, was admitted to the same hospital in 1943 for a course of insulin and electro-shock therapy.[41] It is unsurprising that Blumenthal's private hospital was popular; it was the first to administer insulin and cardiazol treatment, and later electro-shock treatment, in Palestine,[42] and there were even applications for visas from outside Palestine for individuals seeking admission to this hospital.[43] Other Jewish private institutions had Arab patients, too.[44]

This was, in part, what the Palestine Arab Medical Congress had noted in 1945: that while 'practically no Jew will come to an Arab physician for treatment', Jewish physicians had been luring away Arab patients.[45] But if Jewish doctors were happy to treat Arab patients, Jewish families were often unwilling to entrust relatives to shared spaces. After the Second World War, a number of families requested the transfer of relatives from Bethlehem to Jaffa. While some claimed they wished to be closer to their relatives and so visit them more easily,[46] others explicitly expressed their desire to have relatives placed somewhere with fewer Arabs. In February 1947, the father of a Jewish patient at Bethlehem requested that his son, who had been at the hospital for a number of years, be transferred to Jaffa. 'I have the impression', he wrote, 'that it would do him good in respect of his feelings if he would live in another surrounding i.e. between Jewish patients for this reason'.[47] The director of medical service's response to this and similar requests underlined the communal logic to these transfers, as each Jewish patient was exchanged for an Arab patient.[48] If these requests appear to stand in contrast to the willingness of Arab families to send mentally ill relatives to private Jewish institutions in the same years, there was an equivalent request from an Arab father regarding his daughter, who was being treated at Jaffa, in July 1946:

> As my daughter was the only Arab patient between the Jews she suffered many injuries on the head inflicted by the Jewish patients. Her nationality is making her suffer a great deal and I beg that you order her transfer to the Bethlehem mental hospital.[49]

Although the department of health denied she was the only Arab patient, the numbers were small: there were five other female Arab patients, and four male, at Jaffa by 1946.[50] In October, she was exchanged for a female Jewish patient at Bethlehem.[51] What these requests for transfers make clear is that by the end of the mandate, even the population of the government mental hospitals had begun to 'unmix', as a result of pressure from families and with the acquiescence of the British. The fact there were only ten Arab patients in total at Jaffa by 1946 is the most striking evidence for this, given the total number of beds was 175.[52] In the Bethlehem mental institutions, the positions were reversed. Though this may seem unsurprising, given the wider context of calls for a boycott of Jewish physicians and the separation of staff and patients across medical services,[53] it is still striking; as the director of medical services noted as late as 1942, '[w]e mix Arabs and Jews at Bethlehem mental hospital without any trouble'.[54]

Attending to the complex and contingent movements of the mentally ill is important not just because these dragged multiple actors – the department of health, private mental homes, families – into sometimes bitter negotiations, but because these trajectories also intersected with different interests and anxieties at different points – concerns about health could be transformed by financial difficulties, become enmeshed in communal tensions and logics, or form a common ground from which state and subjects could imagine cooperation. Attending to the complexity of the routes taken by patients to the mental hospital is important for another reason, however,

because the route taken could affect their chances for admission. This was not only in the sense that there was predictably less urgency surrounding cases already safely off the streets and in a private institution. Whether particular treatments had been deemed a success or not earlier in an individual's medical history could also be cited in the decision to admit or reject them. In December 1946, for example, Dr Rabinowitz argued V. Weigenfeld should be admitted to the Bethlehem mental hospital for a course of shock treatment because four years earlier, her treatment at Blumenthal's private hospital at Haifa had been judged a success.[55] Conversely, Y. Wagnin, examined in December 1946, had previously undergone treatment 'without beneficial results'; she was therefore deemed incurable and not recommended for admission.[56] As these decisions suggest, there was a particular logic at work in the admission of individuals to government mental hospitals. The following section explores this logic, and the extent to which those seeking the admission of the mentally ill to government institutions were not only aware of it, but attempted to exploit it by framing their petitions in particular ways, ways which evidence the density and complexity of the engagement of ordinary Palestinians with the reasoning and anxieties of the mandate state.

II

In recent years, work by Natasha Wheatley, Lauren Banko, and Nadim Bawalsa has shed light on the petitioning practices of ordinary Palestinians, Arab and Jewish. These have largely focussed on matters of sovereignty, statehood, and Palestine's place within circuits of international governance.[57] Petitions on the mentally ill reveal another, more quotidian, vision of the state as an actor in the everyday lives of people, an agent they hoped might be capable of intervening to provide assistance and care for their sick. In this part of the article, the petitions directed to the mandate government on the mentally ill are read for what they reveal of petitioner and petitioned

alike. As should already be clear, the perspective offered by these petitions is not of an active state and passive population, but in many cases the reverse; a state reacting to the initiatives of Palestinian families.

This is not to say the mandate was wholly passive or reactive. At various points it set out the logic by which decisions about admission to its mental institutions were to be made, logic with which petitioners engaged in their efforts to secure treatment for relatives. We have already seen some of this logic, in the refusal of the government to admit cases they found to be chronic, incurable, or otherwise not likely to benefit from treatment. The problem posed by these patients was given elaboration by a government medical officer in 1945, commenting on a number of cases which had been examined for their suitability for admission to government mental hospitals. They were all unsuitable for admission, he found, because:

1. They are all of chronic nature.
2. They are unlikely to benefit by electro-shock treatment.
3. They are unsuitable for teaching purposes.
4. They will, if admitted to this hospital, remain there for the rest of their lives.[58]

While the importance of the first and last is obvious, given the overcrowding of government mental hospitals throughout this period, the second and third are worth further consideration, as they suggest how government logic on the subject changed over time. The second criterion was contingent on the arrival of electro-shock machines into the hospitals of Palestine, a development of the 1940s: the first electro-shock treatment in a government mental hospital was undertaken in March 1945.[59] This opened up new ways of managing the mentally ill, as it became possible for the department of health to admit a case for a definite period of time only – usually

six months – as they underwent a course of electro-shock treatment.[60] This seemed to hold the key to reducing overcrowding, by freeing up more beds more quickly than in the past. The third criterion, meanwhile, is also striking, because it suggests that more attention was – right at the end of the mandate – being paid to developing a more specialized body of medical professionals on the payroll of the department of health. The timing of this push towards greater professionalization fits with the emphasis placed by the post-war government in Britain on colonial development,[61] as well as with local impulses to professionalization like the formation of the Palestine Arab Medical Association. Thus at conferences held in the last years of the mandate, government medical superintendents gave much attention to the question of keeping pace with the latest medical developments.[62]

If the introduction of new methods of treating the mentally ill meant the medical logic by which the department of health made decisions about admissions changed over time, a second, parallel logic, turning on the question of public safety, remained a constant across the mandate. Indeed, outside the department of health, this was the key lens through which government officials viewed the mentally ill. In the census of 1931, for instance, the census superintendent explicitly identified the 'insane' which the census sought to enumerate as those who 'display the most violent forms of emotional excitement and not… merely passive subnormal victims of mental instability'.[63] The police, too, raised concerns about the 'menace' posed by lunatics 'at large'.[64] A fixation on the violently insane can be traced throughout the period, and the decisions of the department of health regarding admissions reflected this prioritisation. In 1936 a senior medical officer explained that, accommodation being so limited, 'the policy of this department has been to admit violent cases only, who are considered dangerous to themselves and others'.[65]

These twin logics governing admissions decisions were articulated most clearly in April 1946, by the director of medical services: 'we have to select cases for admission on the grounds of (a) likelihood of responding to treatment and (b) public safety'.[66] While petitioners evidenced a high degree of engagement with the latter logic, frequently framing their petitions in terms of

the threat to public safety relatives posed, engagement with the former logic seems to have been more uneven. Around the time electro-shock therapy was first used in a government mental hospital, a number of petitioners began to deploy new strategies of representation: in December 1945, R. Sehayek of Tel Aviv asked for his daughter to be admitted so that 'she might eventually be cured under proper medical treatment';[67] in February 1946, S. Zimbol and I. Shapiro of Petah Tikva made a similar argument in relation to their ward when they claimed that, on account of her youth, 'she will probably benefit by treatment'.[68] In neither case did the examining medical officer agree: both were chronic schizophrenics, thus 'unsuitable for shock treatment'.[69] But precisely *because* they were suffering from schizophrenia, admission was judged urgent; although unlikely to recover, they were too dangerous to be left with their families. What is striking is that rather than rely on this language of danger in the first instance, these petitioners instead sought to exploit the shift in representations of the hospital as a place of treatment rather than merely confinement. That these petitioners were Jewish might be taken to suggest greater familiarity with new treatments among Jews coming from Europe than Arabs, but this would not be entirely accurate. Just as Jacob Norris has complicated the assumption that middle-class modernity was brought to Palestine largely by external actors by focussing on the figure of the returning émigré,[70] there is a diasporic dimension to Palestinian Arab engagements with psychiatric treatments. Some individuals received insulin and electro-shock treatments while in America years before they were available in Palestine, such that they returned with knowledge of these treatments – and, in cases of relapse, demanded them again.[71] But if petitions evidence an awareness on the part of certain petitioners at least of the latest developments in the field, the fact this strategy ultimately failed suggests the limits of their ability to read the mandate correctly. As Lori Allen has argued was the case in the King-Crane and other commissions to Palestine, here too petitioners took the state at its word and stumbled on the 'gap between the explicit and implicit rules of the game'.[72]

If concerns about public safety continued to be the most potent in the eyes of mandate officials, even after the introduction of new treatments, there were a number of different ways in which the mentally ill could be represented as posing a threat to public order. One of the most important was the gendering of this threat. The idea of mentally ill women roaming the streets 'at large' generated a particular kind of gendered anxiety, raised in petitions and taken seriously by the department of health. In 1944, Dr Yacob petitioned the department about a lunatic woman at Beit Jala. She was examined by Dr Malouf, of the government mental hospital at Bethlehem, but he dismissed her case as not urgent; she suffered chronic epilepsy and some 'weak-mindedness'.[73] But Yacob appealed this, describing her as 'a subject of circular insanity'. As well as describing her violent behaviour during these periodic fits of insanity, he recounted a recent distressing incident. Her mother and friends usually chained her up or locked her in a room during these fits, but if not restrained, 'then she goes to the street naked, roaming about here and there'. 'It has happened lately that while thus going about', Yacob continued, 'two policemen… seized her and took her to a lonely place and used her illicitly at night and left her in a ditch, where she was found on the following day after long and careful search by her poor mother.'[74]

The response of the director of medical services was cool in tone, but he was clearly affected. 'Although specially urgent grounds for admission are not present,' he wrote, 'her name has been placed on the waiting list and will be considered when a vacancy occurs.'[75] It was possible to frame anxieties about the sexuality of insane women in other ways, too. The mukhtars of Lifta village, just outside Jerusalem, wrote to the director of medical services in May 1946 on the subject of a woman of twenty-five who was 'in a serious condition and has become dangerous to public safety in view of her repeated molestations'. 'Her aged father', they continued, 'is unable and unfit to control her'; this heightened their fears that 'she may be assaulted or even raped', an event which they warned would precipitate 'a serious breach of the peace'.[76] The failure of the father to control his family had potentially public consequences, and

the mukhtars turned to the colonial state as the ultimate guarantor of paternal authority. Whether they were successful or not is unclear, but what is striking is that they understood the mandate as operating in much the same way that Elizabeth Thompson has argued the French mandate in Syria and Lebanon did – a parallel to which we will return.[77]

Attempts to activate mandatory concerns about public order were not always framed in terms of the sexuality of mentally ill women, but could be cast in more overtly political terms. In the midst of the Arab revolt in 1936, Zipporah Bloch of the Vaad Leumi's social services section wrote to the senior medical officer of Jerusalem about a woman in Nachalat Zion who was 'inciting disorder… by calling upon the Jews to kill the Arabs'. 'We feel that at a moment such as this', she warned, 'much harm can be done by just such insane ravings', and called for the health department to take charge of her. If not, 'the government must accept the responsibility for the outcome of her rantings as long as she is left at large'.[78] Another way to frame the potential of the insane to generate outrage was in terms of religious sentiment. This was clearest in the case of a man reported as going naked around Mea Shearim, an ultra-orthodox neighbourhood in Jerusalem. The local committee petitioned the department of health in January 1933, declaring his nudity to be 'against morals and religion', and urging the department to remove him, 'whereby the honour of man and religious feelings will be saved'.[79] The chief rabbi intervened in the case,[80] but the director of health was not swayed.[81] Petitioners in this instance appeared to overestimate the mandate's anxiety about religious sensitivities at a time of relative quiet.[82]

As well as these attempts to frame the mentally ill, male and female, as threatening public order, another powerful strategy for representing the mentally ill was in terms of the threat they posed children. While there were cases in which mentally ill men were represented as threatening their children,[83] the majority involved mothers. Bloch wrote to Dr Katznelson of the health section of the Vaad Leumi in January 1935 about the case of a pregnant woman who had been abandoned by her husband, and was living with her widowed mother and her young child in Givat Shaul. Bloch described her as 'very violent'; she beat her mother, and 'frequently attempts

to strangle her child'.[84] This was clearly the most shocking part of the case, and it was picked up and amplified by Katznelson in his own note to the director of medical services. 'This lunatic attempted to strangulate her one-and-a-half-year-old child,' he wrote, 'and there seems to be imminent danger to the life of the child if she is not separated immediately.'[85] This was not an isolated case. A petition signed by several mukhtars and residents of Jerusalem also stressed this aspect of another case in April 1948, noting that a woman had tried several times to suffocate the people around her, making her a danger to herself and, in particular, her children.[86] Doctors employed by the health department echoed these concerns. Dr Malouf examined a third case in February 1937, and recommended her for urgent admission, 'as she is a dangerous and violent lunatic who, on several occasions, attempted to kill her own child'.[87]

The possibility that women might harm their own children, then, clearly formed a shared point of anxiety for families, the department of health, and other mediating bodies. While it would be easy to ascribe this to a betrayal of some 'natural' script for motherhood, it would also be lazy and incorrect, as anthropologists like Nancy Scheper-Hughes have powerfully argued.[88] Instead, it is important to interrogate these anxieties about motherhood as historically produced. Across the region in the decades before the First World War, ideas about domesticity, femininity, and maternity were being taken up, reworked, and pressed into the service of a variety of purposes by *nahda* intellectuals, Egyptian nationalists, and returning migrants aspiring to middle-class family life.[89] Set against this regional backdrop, it is unsurprising that for Arabs and Jews in Palestine too, motherhood was in the process of profound transformations across the mandate period. As elsewhere, being a mother was recast from a set of practices and dispositions picked up naturally from experience and the example of older generations, to requiring a specific kind of education in schools, infant welfare centres, the press, and other public arenas. At a time when the government, Zionist organisations, and Palestinian nationalists all viewed the production of particular kinds of mothers as critical to realising wider political projects, women who tried to kill

their own children represented a deeply shocking subversion of the model of the hygienic, responsible, and nurturing mother.[90]

This was thus one of the most potent representational strategies petitioners could use. But petitioners did not rely solely on the contents of their petitions to secure admission. In a move suggestive of how they understood the mandate as operating, petitioners also turned to important individuals or bodies as intercessors. What is striking is that those figures who were called upon to act as intercessors in Palestine match up with those Elizabeth Thompson presents as forming a pillar of French authority in Syria and Lebanon, that is, a clientele of paternalistic elites who acted as intermediaries of the regime.[91] We have already seen a number of cases in which mukhtars intervened, but, as in the French mandate, religious figures were also notable intercessors: the Latin patriarch, Anglican bishop in Jerusalem, and others took the cases of their co-religionists to the government on a number of occasions.[92] The importance of religious – particularly Christian – figures in this connection is unsurprising. As Laura Robson argues, the British sought to apply a rigidly communal vision of society to Palestine, in a way which disempowered the Arab Christian community in the long-term even as it strengthened the hand of Arab Christian leaders in the short-term to negotiate with the mandate government.[93]

A second important group of intercessors can also be mapped onto another pillar of French authority identified by Thompson: bureaucrats.[94] The director of education intervened in a number of cases over the 1940s,[95] as did the postmaster general.[96] While intercession by these figures did not always work, sometimes it did. In September 1932, the postmaster general was asked to intercede on behalf of a former employee of his department, who suffered a 'mental disturbance' while stationed in Jerusalem in 1929.[97] What is striking about this case is that although the letter explicitly described his illness as 'uncurable', which would usually disqualify the mentally ill from admission unless they were extremely violent, the acting director of health proposed to give the case precedence once new beds became available in the second government mental hospital at Bethlehem, then nearing completion.[98] Here again the gap between the explicit

and implicit rules of the game, as Lori Allen puts it, becomes visible, and the ability of particular intercessors to leverage the state to the advantage of their clients comes into view. While the parallels with the French mandates are clear, there are also echoes here of Ilana Feldman's characterisation of government in Gaza under the mandate as tactical, not strategic; focussed more on coping with current conditions than long-term planning, and thus invested in keeping the possibility of exceptions alive.[99] For Feldman, this was not unique to Gaza, and the petitions examined here confirm the wider applicability of this characterisation.

But if the idea of tactical government captures the degree to which the mandate kept open a space for exceptions, it is ultimately the label paternalistic – hitherto applied to the French rather than British mandates in the Middle East – which has the most resonance. In Thompson's usage, this term conveys both the ability of mediating elites to broker services to their clientele, and the essential maleness of authority within that system.[100] Not only were all intercessors male, but the petitions represented mentally ill women as posing a particular threat to the social order. Women could leverage paternalism to their own advantage, however. This kind of manoeuvring is clear in the letters of a mother from Jaffa to the director of medical services. After receiving a noncommittal reply to her first letter in June 1935 requesting the admission of her son, she wrote again in July, framing her plight in the following terms:

> Please answer my demands and save the life of my family, my son who is living a very miserable and unhealthy life, my little children who are becoming disappointed with their lives, and at last my own life. I am a woman, very weak, unable to give help to my beloved lunatic son, nor a power to exert in looking after my little children. Please be merciful![101]

This time, she was successful; that month, the director of health made arrangements for her son's admission.[102] As Kenda Mutongi has argued in a very different context, this mother, like

those widows whose strategies she explores in Kenya, 'by invoking the very gender roles that were designed to control them, by… turning the language of patriarchy into one of entitlement, were able to get what they needed and at the same time enforce gender roles upon men'.[103] Gendered understandings of the mandate are, indeed, striking in their ubiquity: the mandate as a formulation in international law, with its language of trusteeship, has long been characterized as paternalistic; while opposition to it, as Ted Swedenburg has shown, was couched in gendered terms too, with the great revolt cast in peasant memories as a reaction to the violation of their honour and the rape of their land.[104] The tactics deployed by the petitioners examined here add a further layer to this gendered rendering of the mandate, demonstrating how Palestinians also sought succour from the state on the basis of its paternalism. That their attempts to negotiate with the state on that basis were met with no small degree of success might be taken as evidence of the astuteness of this reading of the mandate state in Palestine.

III

The expansion of provision of services for the care and treatment of the mentally ill by the British mandate over the course of the 1930s and 1940s did not result in the development of an inflexible and impersonal system by which patients were assessed, and admitted or rejected. But it generated particular expectations about what the state did. Petitions were by no means novel to this period, but as the absence of petitions about the mentally ill before the 1930s and the shifts in the language of these petitions in the mid-1940s both suggest, these expectations did open up and help shape new avenues of approach to the state amongst Palestinians. But the state might well say one thing and do another, as petitioners who took seriously the revolution promised by the introduction of new somatic treatments in the 1940s discovered to their detriment. Rather than operating rigidly in line with the logics articulated by the director of

health and other senior medical officers, decisions about the admission of patients could be made on the basis of gendered anxieties and the interventions of particular intercessors. The persistence and indeed expansion of this paternalistic mode of operation into the era of the colonial welfare state has been noted in the case of the French mandates.[105] But, as more recent comparative works on the Middle Eastern mandates have sought to emphasize, this phenomenon was not unique to the French.[106] From the perspective of the petitions examined here, the British mandate in Palestine seems to have more in common with its French contemporaries than is allowed in the usual rendering of Palestine as exceptional. This is not to argue that there were not elements in the story of mental illness in Palestine which were exceptional; setting Palestine alongside Claire Edington's work on French Indochina, or Jonathan Saha's on Rangoon, reveals the limits of a comparative colonial perspective. This article has argued that it is important to remain aware of Palestine's stubborn specificities, while locating it in its regional setting as a mandate state.

If the petitions thus suggest that the distinction between the governing styles of the French and British mandates has been overdrawn, they also complicate straightforwardly binary readings of the therapeutic and experiential worlds of the Arab and Jewish mentally ill, which have tended to dismiss the complexity of the former in particular. Rather than resigning themselves to caring for mentally ill relatives at home, the petitions reveal many Palestinian Arabs to have been active and determined in pursuing treatment options for relatives, whether at home, government hospitals, or private institutions in Palestine and further afield. Indeed, this engagement with the question of the mentally ill seems exceptional; other illnesses did not lead Palestinians to inundate the government with petitions in the same way.[107] The limits of expert authority in definitively assessing mental illness, which seemed to be bound up with subjectivity in ways that other disorders of the body were not, enabled families – in Palestine as in other colonial contexts – to put forward their own claims about the condition of their relatives and so position themselves as interlocutors, albeit unequal ones, with the government in debates over

their future. For Natasha Wheatley, the importance of petitions sent to the Permanent Mandates Commission by Palestinians in this period does not lie in the fact that they won for petitioners tangible redress, since very few of them accomplished this; instead, they matter because they 'forced painstaking rebuttals from mandatory authorities and long discussions at the PMC's meetings', thereby contributing to the creation of norms.[108] The reverse seems to be true here. A significant number of petitions about the mentally ill did, in fact, meet with concrete action, even if 'only' a medical examination or adding a name to a waiting list. And we have seen more striking examples of the kinds of impact these petitions could have, in the potential of petitioners to precipitate the unmixing of patient populations towards the end of the mandate. It is in the realm of 'talk', and the generation of norms, that the impact of these petitions seems more muted. Confronted with reasoning it had itself articulated, the state often succeeded in shaking off obligations by which petitioners imagined it to be bound, thereby subverting rather than contributing to the creation of norms. If an impersonal Weberian state failed to emerge as a result, this article has argued that this was a productive failing, creating opportunity for exception in a way which suited – albeit in different ways, and to different degrees – state and subject alike.

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* I am grateful to Sujit Sivasundaram and the anonymous reviewers for their comments and kind encouragement. I also wish to express my deepest thanks to Andrew Arsan, who shepherded this article from start to finish.

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[1] Jonathan Saha, 'Madness and the making of a colonial order in Burma', *Modern Asian Studies,* 47 (2013), pp. 406-7.

[2] Zeina Ghandour, *A discourse on domination in mandate Palestine: imperialism, property, and insurgency* (Abingdon, 2010), p. 3.

[3] See Jacob Norris, *Land of progress: Palestine in the age of colonial development, 1905-1948* (Oxford, 2013).

[4] Ann Laura Stoler and Frederick Cooper, *Tensions of empire: colonial cultures in a bourgeois world* (Berkeley, 1997), pp. vii-viii.

[5] Amongst others, David Arnold, 'Orphans and vagrants in India in the nineteenth century', *Journal of Imperial and Commonwealth History,* 7 (1979), pp. 104–27; Julia Clancy-Smith and Frances Gouda eds., *Domesticating the empire: race, gender, and family life in French and Dutch colonialism* (Charlottesville, 1998).

[6] Natasha Wheatley, 'The mandate system as a style of reasoning: international jurisdiction and the parcelling of imperial sovereignty in petitions from Palestine', in Cyrus Schayegh and Andrew Arsan eds. *The Routledge handbook of the history of the Middle East mandates* (London, 2015), pp. 106-122; Lori Allen, 'Determining emotions and the burden of proof in investigative commissions to Palestine', *Comparative Studies in Society and History,* 59 (2017), pp. 385-414. For an exception: Yuval Ben-Bassat, *Petitioning the sultan: protests and justice in late Ottoman Palestine, 1865-1908* (London, 2013).

[7] Ilana Feldman, *Governing Gaza: bureaucracy, authority, and the work of rule, 1917-1967* (Durham, 2008), pp. 167-8.

[8] Saha, 'Madness', pp. 414-6.

[9] Many others would also have been destroyed during the mandate through routine bureaucratic practices: Feldman, *Governing*, pp. 31-61.

[10] For example, a petition by J. Algazi of Tel Aviv, 26 Dec. 1939, forwarded to the Tel Aviv mayor and extant in Tel Aviv Municipal Archives, 4-4737. But these do not predate 1930s, and mostly relate to other matters (e.g. noise, by residents of King George Avenue, 7 June 1942, Jerusalem Municipal Archive, A/14/23), are requests for subsidies from private institutions (e.g. director of institution at Bnei Braq, 31 July 1936, Central Zionist Archive, J1\6203), or directed to municipal – not government – authorities (e.g. to mayor of Haifa, 5 Nov. 1944, Haifa Municipal Archive, 00388/6). I have not found similar petitions in the British National Archive.

[11] Rakefet Zalashik, *Das unselige Erbe: die Geschichte der Psychiatrie in Palästina und Israel* (Frankfurt, 2012).

[12] An approach pioneered by Zachary Lockman, 'Railway Workers and Relational History: Arabs and Jews in British-Ruled Palestine', *Comparative Studies in Society and History,* 35 (1993), pp. 601-27.

[13] David Wright, 'Getting out of the asylum: understanding the confinement of the insane in the nineteenth century', *Social History of Medicine,* 10 (1997), p. 139.

[14] See Jonathan Sadowsky, *Imperial bedlam: institutions of madness in colonial southwest Nigeria* (Berkeley, 1999); Lynette Jackson, *Surfacing up: psychiatry and social order in colonial Zimbabwe, 1908-1968* (London, 2005); Claire Edington, 'Going in and getting out of the colonial asylum: families and psychiatric care in French Indochina', *Comparative Studies in Society and History,* 55 (2013), pp. 725-55; Sally Swartz, *Homeless wanderers: movement and mental illness in the Cape colony in the nineteenth century* (Cape Town, 2016).

[15] Most recently, Erik Linstrum, *Ruling minds: psychology in the British empire* (Cambridge, MA, 2016).

[16] See Sandy Sufian, 'Arab health care during the British mandate, 1920-1947', in T. Barnea and R. Husseini eds. *Separate and cooperate, cooperate and separate* (Westport, 2002), pp. 9-30.

[17] Marcella Simoni, 'A dangerous legacy: welfare in British Palestine, 1930-1939', *Jewish History,* 13 (1999), pp. 92-96.

[18] Ibid., p. 95.

[19] A. Rosenthal to senior medical officer [SMO] Jerusalem, 20 Oct. 1931, Israel State Archive [ISA] M6552/17. See also acting director of medical services [DMS] to chief secretary [CS], 6 Aug. 1938, ISA M1752/20.

[20] Decree of 19 Safar 1293 [1876], amended 3 Mar. 1892, ISA M6555/8.

[21] SMO Jaffa to DMS, 16 Apr. 1935, ISA M6628/4.

[22] Mother of S.M.S. Ayyad, Jaffa, to DMS, 8 June 1935, ISA M6628/4.

[23] E. Frankel, Jerusalem, to high commissioner, 18 Apr. 1937, ISA M6627/28.

[24] K.H. al-Dirr, Beit Hanina, to high commissioner, 23 Jan. 1937, ISA M6627/28.

[25] Medical officer, villages, to SMO Jerusalem, 4 Mar. 1937, ISA M6627/28.

[26] See medical report on R.M. Fityani, Bethlehem, 14 Nov. 1946, ISA M6627/31.

[27] I.A. Wahid, Jerusalem, to DMS, 18 May 1938, ISA M6627/29.

[28] A.A. Kamal, Mea Shearim, to superintendent, district health department, 3 Apr. 1937, ISA M6627/28.

[29] One woman did not visit her hospitalised sister for four years to avoid these fees. See letter intercepted by Jerusalem postal censors to S. Cassis, Bolivia, 24 Sept. 1939, ISA M6627/29.

[30] Edington, 'Going', pp. 751-2.

[31] Roger Owen and Sevket Pamuk, *A history of Middle East economies in the twentieth century* (London, 1998), p. 60.

[32] Palestine Arab Medical Association, to DMS, 15 July 1945, ISA M325/19.

[33] DMS to CS, 17 Nov. 1937, ISA M6629/13.

[34] See acting director of public works to CS, 25 Jan. 1946, ISA M325/38.

[35] Zalashik, *Erbe*, pp. 71-2.

[36] See ISA M4986/38.

[37] Annual reports of the Lebanon hospital for mental diseases, 1937 and 1938, in Saab Medical Library, American University of Beirut.

[38] See Joel Beinin, *Workers and Peasants in the Modern Middle East* (Cambridge, 2001), p. 114.

[39] ISA M551/19.

[40] Supreme Muslim Council to DMS, 17 Nov. 1946, ISA M6627/31.

[41] Medical report on Y.A. el-Masri, Bethlehem, 16 Nov. 1946, ISA M6627/31.

[42] See Kurt Blumenthal, 'Treatment of schizophrenia with insulin and cardiazol', *Harefuah* (1938), pp. 173-9, and 'Electro-shock therapeutics in psychiatry', *Harefuah* (1942), pp. 4-7.

[43] ISA M4342/42.

[44] H.F. Khalidi, Jerusalem, to acting DMS, 21 Aug. 1947, ISA M6627/31.

[45] Palestine Arab medical association, to DMS, 15 July 1945, ISA M325/19.

[46] J. Levy, Rishon-le-Zion, to DMS, 29 Aug. 1947, ISA M6627/31; C. Wachholder, Tel Aviv, to DMS, 20 Dec. 1945, ISA M6628/6.

[47] A. Kletter, Jerusalem, to DMS, 1 Feb. 1947, ISA M6627/31.

[48] DMS to medical superintendent, government mental hospital [GMH] Jaffa, 10 Feb. 1947, ISA M6627/31.

[49] H. Bakr, Jerusalem, to DMS, 15 July 1946, ISA M6628/6.

[50] Assistant SMO, Jaffa, to DMS, 10 Aug. 1946, ISA M6628/6.

[51] Medical superintendent, GMH Bethlehem, to DMS, 17 Oct. 1946, ISA M6628/6.

[52] Annual reports, ISA M323/22.

[53] Sufian, 'Health care', pp. 18-21.

[54] DMS to CS, 5 May 1942, ISA M323/30.

[55] A. Rabinovitz, GMH Jaffa, to SMO Jaffa, 16 Dec. 1946, ISA M6648/6.

[56] Medical report on Y. Wagnin, Bethlehem, 5 Dec. 1946, ISA M6627/31.

[57] Natasha Wheatley, 'Mandatory interpretation: legal hermeneutics and the new international order in Arab and Jewish petitions to the League of Nations', *Past and Present,* 227 (2015), pp. 205-48; Lauren Banko, 'Claiming identities in Palestine: migration and nationality under the mandate', *Journal of Palestine Studies,* 46 (2017), pp. 26-43; Nadim Bawalsa, 'Legislating exclusion: Palestinian migrants and interwar citizenship', *Journal of Palestine Studies,* 46 (2017), pp. 44-59.

[58] Assistant SMO, Jaffa, to DMS, 11 Dec. 1945, ISA M6628/6.

[59] Clinical assistant, GMH Bethlehem, to superintendent, MH Jaffa, 27 Aug. 1945, ISA M6602/17.

[60] For instance, medical report on R.M. Fityani, Bethlehem, 14 Nov. 1946, ISA M6627/31.

[61] See Ronald Hyam, *The Labour government and the end of empire, 1945-1951* (London, 1992).

[62] Minutes of medical superintendents' conference, Haifa, 15 July 1947, ISA M6576/28.

[63] Eric Mills, *Census of Palestine 1931* vol. 1 (Alexandria, 1933), p. 224f2. The enumeration of the insane was part of a wider inquiry into infirmities in the census, and was not unusual, having been included in British colonial censuses since the nineteenth century.

[64] District superintendent, Southern district, to president, Jaffa district court, 1 Sept. 1930, British National Archives, CO733/201/2.

[65] SMO, Jerusalem, to district commissioner, Jerusalem, 16 June 1936, ISA M6627/28.

[66] DMS to E. Harris, Nahariya, 11 Apr. 1946, ISA M6628/8.

[67] R. Sehayek, Tel Aviv, to DMS, 16 Dec. 1945, ISA M6628/6.

[68] S. Zimbol and I. Shapiro, Petah Tikva, to DMS, 2 Feb. 1946, ISA M6628/6.

[69] SMO, Jaffa, to DMS, 1 Jan. 1946, ISA M6628/6; SMO, Jaffa, to DMS, 28 Jan. 1946, ISA M6628/6.

[70] Jacob Norris, 'Return migration and the rise of the Palestinian nouveaux riches, 1870-1925', *Journal of Palestine Studies*, 46 (2017), pp. 61-75. Lily Balloffet highlights the investment in health amongst the Syrian-Lebanese diaspora in Latin America too, in 'Syrian refugees in Latin America: diaspora communities as interlocutors', *LASA Forum*, 47 (2016), pp. 11-2. I am grateful

to one of the reviewers for pushing my thinking on this, though I can only begin to address it here.

[71] Medical superintendent, GMH Bethlehem, to DMS, 8 Mar. 1947, ISA M6627/31. Electro-shock therapy was also in use closer to home by the Second World War: see *Annual report of the Lebanon Hospital for the Insane* (1942), p. 15.

[72] Allen, 'Determining', p. 387.

[73] M. Malouf to SMO, Jerusalem, 10 Aug. 1944, ISA M6627/30.

[74] M. Yacob, Beit Jala, to Chief Medical Officer, 31 Aug. 1944, ISA M6627/30.

[75] Acting DMS to M. Yacob, Beit Jala, Sept. 1944, ISA M6627/30.

[76] Mukhtars of Lifta village to DMS, 24 May 1946, ISA M6627/31.

[77] Elizabeth Thompson, *Colonial citizens: republican rights, paternal privilege, and gender in French Syria and Lebanon* (New York, 2000).

[78] Z. Bloch, Vaad Leumi, to SMO, Jerusalem, 30 Apr. 1936, ISA M6627/28.

[79] Mea Shearim committee to DMS, 24 Jan. 1933, ISA M6627/26.

[80] Chief Rabbi to CS, 28 June 1933, ISA M6627/26.

[81] DMS to CS, 19 July 1933, ISA M6627/26.

[82] Though Douglas Duff, who joined the Palestine police in 1922, recounts one episode in which the potential for religious excitement generated by a 'poor, deluded fanatic' was met with a swift police response, so not everyone was as relaxed about this: Douglas Duff, *Bailing with a teaspoon* (London, 1953), pp. 118-9.

[83] Z. Bloch to district commissioner, Jerusalem, 12 May 1933, ISA M6627/26.

[84] Z. Bloch to A. Katznelson, Vaad Leumi, 24 Jan. 1935, ISA M6627/27.

[85] A. Katznelson to DMS, 25 Jan. 1935, ISA M6627/27.

[86] Note on a petition to DMS, 13 Apr. 1948, ISA M6627/31.

[87] SMO, Jerusalem, to DMS, 9 Feb. 1937, ISA M6627/28.

[88] Nancy Scheper-Hughes, *Death without weeping: the violence of everyday life in Brazil* (Berkeley, 1992).

[89] Amongst others, Akram Khater, *Inventing home: emigration, gender, and the middle class in Lebanon, 1870-1920* (Berkeley, 2001); Beth Baron, *Egypt as a woman: nationalism, gender, and politics* (Berkeley, 2005).

[90] Ellen Fleischmann, *The nation and its 'new' women: the Palestinian women's movement, 1920-1948* (Berkeley, 2003); Sheila Katz, *Women and gender in early Jewish and Palestinian nationalism* (London, 2003); Ela Greenberg, *Preparing the mothers of tomorrow: education and Islam in mandate Palestine* (Austin, 2010).

[91] Thompson, *Colonial citizens,* pp. 42-3.

[92] For examples: Latin patriarch to DMS, 3 Oct. 1933, ISA M6627/26; Reverend J. Khadder, St George's Cathedral, Jerusalem, to DMS, 12 Feb. 1936, ISA M6627/28; Anglican bishop in Jerusalem to acting DMS, 29 July 1944, ISA M6627/30.

[93] Laura Robson, *Colonialism and Christianity in mandate Palestine* (Austin, 2011).

[94] Thompson, *Colonial citizens* pp. 59-65.

[95] See director of education's letters to DMS, 24 Feb. 1941, ISA M6627/29; to DMS, 30 June 1944, ISA M6627/30; and to Dr R.S.F. Hennessey, 22 Feb. 1947, ISA M6627/31.

[96] Acting postmaster general to DMS, 4 July 1947, ISA M6627/31.

[97] R. Behrman to postmaster general, 14 Sept. 1932, ISA M6627/26.

[98] Acting DMS to SMO, Jerusalem, 24 Sept. 1932, ISA M6627/26.

[99] Feldman, *Governing,* p. 18; 221-2.

[100] Thompson, *Colonial citizens,* pp. 66-7.

[101] Z. Ayyad, Jaffa, to DMS, 18 July 1935, ISA M6628/4.

[102] SMO, Jaffa, to medical officer, GMH Bethlehem, 24 July 1935, ISA M6628/4.

[103] Kenda Mutongi, *Worries of the heart: widows, family, and community in Kenya* (Chicago, 2007), pp. 7-8.

[104] Ted Swedenburg, *Memories of revolt: the 1936-1939 rebellion and the Palestinian national past* (Minneapolis, 1995).

[105] Andrew Arsan, 'Failing to stem the tide: Lebanese migration to West Africa and the competing prerogatives of the imperial state', *Comparative Studies in Society and History,* 53 (2011), p. 455.

[106] Schayegh and Arsan, *Routledge handbook*.

[107] I have not found a comparable body of petitions on other illnesses; this does not necessarily mean they were never written, but it is nonetheless striking.

[108] Wheatley, 'Mandate system', p. 107.